Today, we will examine the response of the Department of Health and Human Services to the nation’s emergency care crisis.

In times of great tragedy, Americans rely on our emergency care system. Whether because of a car wreck, a heart attack, a stroke, or a pregnancy complication, Americans and their families show up at the doorstep of our nation’s Emergency Rooms seeking critical care everyday. Emergency care is the great equalizer — it is the only form of health care guaranteed to every American, regardless of his or her ability to pay. But in this way, it also provides a chilling snapshot of what is wrong with our nation’s health care system.

We all want emergency care to work effectively for ourselves and our loved ones. When it does work — and it usually does — lives are saved, and lifelong disability is avoided. The many dedicated men and women who staff our nation’s ERs, trauma centers, and ambulance services deserve our appreciation and support.

But when the system fails, it can have fatal consequences.

Earlier this week, USA Today carried a front page story on the health crisis in Houston, where ERs divert ambulances 20% of the time. One doctor described a patient who died after being diverted from a Houston area hospital to one in Austin, 1,600 miles away. “Diversion kills you,” he said.

In my hometown of Baltimore, a city Health Department study documented that between 2002 and 2005, the total hours City hospitals were on “red alert” status, meaning they had no cardiac monitored beds for arriving ER patients, increased by 36%. The length of time it took ambulances to offload patients in the ER increased by 45%, and the number of hours ambulances were diverted from overcrowded ERs shot up by 165%.

Unfortunately, the emergency care crisis is not limited to Houston and Baltimore.

Failures in the ER have led to an increase in preventable death, from treatable conditions like heart disease. An article in this morning's edition of USA Today indicates that seven of our nation's hospitals have worse heart-attack death rates than the national average, while 35 have higher death rates for heart failure.

The LA Times reported this past May that a 40-year-old woman collapsed on the waiting room floor of the ER at Martin Luther King-Harbor Hospital in Los Angeles, while janitorial staff literally mopped the floor around her. Overburdened staff ignored her pleas for help and her boyfriend — desperate for assistance — dialed 911 from the hospital. He was told to find a nearby nurse. His girlfriend died 45 minutes later.

Last month, Newsweek.com described the fiscal challenges facing Grady Memorial Hospital in Atlanta. Grady Hospital supports one of the busiest ERs in state and the only Level I trauma center in a metropolitan area of 5 million people. But on any given day, it is not unusual for 8 Atlanta hospitals to be diverting patients at the same time. What will Atlanta do if Grady closes its ER?

Even here in the District of Columbia, it is not unusual for ambulances to be parked seven-deep in front of one or more of the city's bigger ERs, waiting to off-load patients. Not to be too blunt, but these are the same ERs that Members of Congress and our families would turn to in an emergency.

The fact of the matter is that we have a crisis in emergency care, and it is nationwide.

This begs the question: With a national emergency and trauma care system as fragile as ours, how would we manage the very real threats of a terrorist bombing, a natural disaster, or an outbreak of pandemic flu? Where is the surge capacity?

The Emergency Room crisis is nothing new.

More than 5 years ago, US News and World Report published a cover story entitled, "Crisis in the ER: Turnaways and Delays are a Recipe for Disaster." A copy is displayed on the easel

before me. If you look closely, you will note that — ironically — this issue was published on September 10, 2001.

Five weeks after September 11, Chairman Waxman released a report detailing the national problem of ambulance diversions and the shortage of emergency care. His report identified over 20 states in which hospitals were turning away ambulances because of overcrowding and funding shortfalls.

Subsequent reports reached similar conclusions. A 2003 report by the Centers for Disease Control and Prevention found that ER rooms in U.S. hospitals diverted more than 1,300 patients a day, 365 days per year. A 2003 GAO report documented ER crowding throughout the country. One year ago, the Institute of Medicine of the National Academy of Sciences released a three-volume report on emergency care in the United States health system. This landmark study concluded that our nation's emergency and trauma care system is "at the breaking point."

Last summer, Congress enacted the Pandemic and All Hazards Preparedness Act. This Act assigned responsibility for leading all federal public health and medical responses to public health emergencies to the Department of Health and Human Services.

But despite this clear responsibility, and despite the billions of taxpayer dollars that the Congress has appropriated for biodefense and pandemic preparedness, HHS appears to be ignoring the mounting emergency care crisis.

The Department has not made a serious effort to identify the scope of the problem and which communities are most affected. It has failed to require hospitals that participate in Medicare to report data on the extent of ER boarding and ambulance diversion. It has failed to use its purchasing power through the Medicare program to encourage hospitals to promptly admit ill and injured patients to inpatient units, rather than "boarding" them in ER hallways and forcing staff to divert inbound ambulances. It has done nothing to promote regionalization of highly specialized trauma and emergency care services — a key recommendation of the IOM report.

Worse yet, the Department has recently taken some actions that will make matters worse.

It is undisputed that part of the emergency care crisis is the result of the historic underfunding of safety net hospitals, many of which serve as cornerstones of the trauma and emergency care systems in their communities.

However, rather than asking Congress for additional resources to assist these hospitals, the Department has attempted to bypass Congress by issuing rules that would cut hundreds of millions in supplemental Medicaid funding from these facilities. This makes no sense.

Last month the Congress enacted a one-year moratorium that blocks the Department from implementing these funding reductions. But HHS has shown no signs of modifying its position.

Today we will hear from leading private sector experts on emergency care, trauma care, and ambulance services. They will describe the emergency care crisis from the front lines.

We will also hear from representatives of two agencies within HHS that have a particularly important role to play in addressing the crisis: the Office of the Assistant Secretary for Preparedness and Response and the National Institutes of Health.

I hope that the testimony we hear today will help provide our Committee with an understanding of the emergency care crisis that confronts us all.

Nearly six years have passed since the wake up call of September 11, and HHS has yet to tackle this problem. The time for action is long past due.